STATE OF ARIZONA
DEPARTMENT OF INSURANCE

FIFE SYMINGTON
Governor

ABACUS TOWERS
3030 NORTH 3RD STREET, SUITE 1100
PHOENIX, ARIZONA 85012

SUSAN GALLINGER
Director of Insurance

CIRCULAR LETTER NO. 92-6

TO: ALL INSURANCE TRADE ASSOCIATIONS, INSURANCE MEDIA PUBLICATIONS AND INTERESTED PERSONS

FROM: SUSAN GALLINGER, DIRECTOR OF INSURANCE

DATE: August 25, 1992

RE: UNFAIR DISCRIMINATION IN THE REIMBURSEMENT OF CHIROPRACTORS, OSTEOPATHIC PHYSICIANS AND MEDICAL DOCTORS

On or about September 27, 1990, the Arizona Department of Insurance (ADOI) issued Circular Letter No. 90-12 (subsequently renumbered to 90-5A), outlining the guidelines for the changes in A.R.S. § 20-461, which passed during the 1990 Legislative session. The amendments [A.R.S. § 20-461(A)(16) and (B)] affect, among other things, the reimbursement of and participation in preferred provider networks by physicians holding licenses pursuant to Arizona Revised Statutes, Title 32, Chapters 8 (chiropractic), 13 (medical), and 17 (osteopathic).

As subsequently noted in ADOI Circular Letter No. 91-2, a technical corrections bill introduced in the 1991 Legislative Session subsequently passed as part of H.B. 2027 and made the 1990 provisions applicable to group and blanket disability insurance policies issued in the State of Arizona. The 1991 legislative change nullifies item 7 of Circular Letter No. 90-5A.

Since the enactment of H.B. 2027 on September 27, 1991, ADOI has received numerous inquiries from both the physician community and the insurance industry regarding specific issues arising under these provisions of law. ADOI has attempted to respond to these inquiries on a case-by-case basis. Because inquiries and complaints have continued to arise, I believe it is appropriate to respond to the most universal of these questions by means of this Circular Letter:

Q: May an insurer impose exclusions or limitations on conditions such as "subluxation"?

A: No. The statute is very specific that coverage must be related to the reasonable and necessary services to treat a condition, rather than providing coverage for certain procedures. Some terms for conditions, such as "subluxation," however, are used almost exclusively by the chiropractic profession, and selected exclusions or limitations of "conditions" only by their chiropractic terminology is a direct violation of the statute.

Q: **May an insurer impose exclusions or limitations on treatment modalities, such as spinal manipulation, so long as those exclusions or limitations apply to all types of physicians?**

A: No. Such exclusions or limitations are targeted at the services provided under certain types of licenses (in the case of spinal manipulation, for instance, by chiropractors and some osteopaths), in favor of other forms of treatment, such as surgery. The obvious intent of the law is to permit freedom of choice by consumer as to the type of practitioner (and thus the type of treatment) he or she deems appropriate for the medical condition based upon personal factors.

Q: **May an insurer impose limitations on the number of office visits, so long as those limits are applied equally to all types of physicians?**

A: No. Again, certain types of non-invasive treatment require numerous office visits, while surgery may require only a few. The law permits the patient to select among alternative forms of treatment without discrimination in reimbursement for the treatment.

Q: **If an insurer cannot impose any limitations on the number of office visits, how can the insurer be expected to control its costs?**

A: Insurers are not required to reimburse for treatment that is not medically necessary. Insurers may apply pre-authorization procedures, as well as concurrent utilization review, to ensure that treatment is medically necessary. The standards for pre-authorization and concurrent review, however, may not favor any specific type of licensed practitioner nor any specific form of treatment.

Q: Must an insurer include chiropractors, osteopaths and medical doctors in its preferred provider network?

A: Yes. The language of A.R.S. § 20-461(B) permits an insurer to apply "preferred provider organization requirements" so long as those requirements are "equally applied to all physicians referred to in Subsection A, paragraph 16, without discrimination to the usual and customary procedure of any type of physician."

Q: Does A.R.S. § 20-461(B) ensure participation "on demand" by any physician or physician group that applies?

A: No. Clearly the statute requires an insurer to accept all three types of physicians in its network, but the law does not require an insurer to accept <u>every</u> physician who applies for participation. As stated in ADOI Circular Letter No. 90-5A, "[a] non-discriminatory limit to the number of participating practitioners is permitted." The statute does not establish a "quota" for participation, but implicitly requires a number of physicians of each type that will be sufficient to meet the needs of the insured population, taking into account geographic dispersion of physicians, doctor/patient ratios, and other pertinent factors.

An insurer may not apply certain credentialing criteria to all types of physicians if those criteria, by their terms, would exclude certain types of physicians from participation. If, for instance, the insurer requires all participating physicians to have hospital admitting privileges, this criterion may not be applied to chiropractors, since chiropractors do not admit patients to hospitals. If, on the other hand, the insurer requires all physicians to have practiced under their licenses for not less than three years, this criterion would not unduly discriminate against any single type of physician.

Q: If the insurer subcontracts its network from an independent preferred provider organization (PPO), must the independent PPO include physicians of all types?

A: Not necessarily, because the statute applies only to hospital/medical service corporations, benefit

insurers, and disability carriers. The law does not apply to independent PPOs. However, the mere fact that the independent PPO does not include all types of physicians does not relieve the insurer from compliance with these laws. The insurer remains responsible for establishing an adequate network of physicians practicing under all types of licenses named in the statutes.

Q: **May an insurer meet its obligation to include chiropractors in its PPO network by simply providing PPO benefit levels for care provided by any licensed chiropractor, without specifically naming them in the PPO directory?**

A: No, unless the insurer provides adequate and appropriate notice to the insured of its intent to reimburse any and all chiropractors at PPO benefit levels of reimbursement. An insured wishing to access care at PPO benefit levels will rely on the provider directory as the complete listing of preferred providers through whom the insured may obtain a higher benefit levels of PPO participation. Thus, without adequate notice of the existence of chiropractic services available at PPO benefit levels, the consumer may be misled into choosing care only from those providers listed in the PPO directory.

Any company not yet in compliance with A.R.S. § 20-461(A)(16) and (B) faces sanctions that may include suspension of its certificate of authority and civil penalties. It is imperative that all hospital/medical service corporations, benefit insurers, and disability carriers comply with these provisions immediately.